STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335164	A. BUILDING _____ B. WING _____	10/29/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBOLDT HOUSE REHABILITATION AND NURSING CENTER	64 HAGER STREET BUFFALO, NY 14208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on interview and record review conducted during a Complaint investigation (Complaint # NY 930) during the Standard survey completed on 10/29/18, the facility did not ensure that all alleged violations of abuse, exploitation or mistreatment, were thoroughly investigated. One (Resident #80) of four residents reviewed for abuse did not have a complete and thorough investigation conducted for misappropriation of resident property. The finding is: Review of the facility's policy entitled Personal Property with the revised date of (MONTH) 2012, documented that a representative of the admitting office will advise the resident, prior to or upon admission, as to the types and amount of personal clothing and possessions that the resident may keep in his or her room. Resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. Furthermore, that the facility will promptly investigate any complaints of misappropriation or mistreatment of [REDACTED]. 1. Resident #80 was admitted to the facility on [DATE] had [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS - a resident assessment tool) dated revealed the resident had severe cognitive impairment, usually understands and is usually understood. The Misappropriation of Resident Property Report dated 9/26/18 documented that it was reported to the Social Worker the resident had several missing personal items. The report did not give a description of the missing items, but instead documented to see attached receipts. Attached to the report were photo copies of eight receipts for mulitple various personal items that included toiletries, and several clothing items. The Social Worker documented that she checked with the family, social services, nursing, and activities departments. The Social Worker personally checked with laundry and the missing items were not located. The documented resolution was that the items cannot be verified that they were purchased for resident. The Administrator signed and dated the report on 10/1/18. Review of a facility document entitled Clothing/ Items for Labeling/ Delivery, provided by the Director of Laundry on 10/26/18 at 10:30 AM revealed all the items listed on the document reconciled with the photocopy receipts provide by the family. During an interview on 10/25/18 1:08 PM, the Director of Laundry stated when a family member brings in clothing it all gets labeled, washed and every article is documented on the Clothing/ Items for Labeling/ Delivery Sheet before the clothing gets delivered to the unit. During an interview on 10/26/18 at 10:08 AM, the Administrator stated the process for missing resident property, is that the Nursing Supervisor gets notified and we start a search for the missing items. He also stated that we do have a missing report that gets filled out and we try to find the items. If we can't find them and it is a credible loss I replace the items. Additionally, when interviewed regarding credible the Administrator stated, if they have receipts and or it was checked in through the laundry department I reimburse the resident. During an interview on 10/26/18 at 10:16 AM, Social Worker (SW#2), stated when a patient gets admitted and has valuables the nursing staff bring them to me. I hold on to them until the resident can lock them up, if they have a lockable drawer or until the family can take them home. She then stated, we do have a Misappropriation of Resident Property Report that I usually fill out. She was aware the resident had missing personal items, as the resident's sister came in and a report out was filed. The SW took the family member to the laundry room and they looked for the items, and they were unable to locate any of the items. The SW further stated, I asked her to bring in receipts for the items, but the receipts that she brought in all reflected socks, underwear and boys uniform pants. I told her that I could not accept these receipts because they did not reflect items for a man. 415.4(b)(3)
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on interview and record review conducted during a Complaint investigation (Complaint #NY 034) completed during the Standard survey on 10/29/18, the facility did not ensure that each resident received treatment and care based on the comprehensive assessment of the resident that is in accordance with professional standards of practice for one (Resident #241) nine residents reviewed for diabetic management. Specifically, the incorrect transcription of medication orders resulted in the administration of insulin (used to decrease glucose (blood sugar) levels in the blood). The administration insulin and the lack of monitoring glucose levels led to critically low blood glucose levels, and subsequently hospitalization . This resulted in actual harm that is not immediate jeopardy. The findings are: The policy entitled Nursing Care of the Resident with Diabetes Mellitus dated (MONTH) (YEAR) documented the purpose of the guideline was to review the most common and serious conditions and complications associated with diabetes, help the resident control his/ her diabetes with diet, exercise, and insulin (as ordered), and to prevent recurrent [MEDICAL CONDITION]/ [DIAGNOSES REDACTED]. The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. The physician will order the frequency of glucose monitoring. Additionally, residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation. The survey team requested a policy on readmission/ admission procedures on 10/29/18 at 11:00 AM and none was provided by the facility. 1. Resident #241 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-a resident assessment tool) dated 2/19/18 documented the resident was cognitively intact, was understood and understands. The MDS also documented the resident received insulin injections. The current Comprehensive Care Plan with an initiated date of 1/24/18 had no documented plan for the use of insulin and glucose monitoring. A Change of Condition Progress Note dated 2/4/18 at 4:43 PM by Licensed Practical Nurse (LPN #2) documented around 8:00 AM, the resident was found unresponsive, had pursed lip breathing with clear mucous coming from their mouth. Several attempts were made to arouse the resident without success. A blood glucose level was obtained and documented as 33 (normal 70-130). The resident was administered [MEDICATION NAME] (medication used to raise concentration of glucose in bloodstream) IM (intramuscular- injection directly into the muscle) per the physician's orders [REDACTED]. The resident became more alert and responsive after the administration of [MEDICATION NAME]. Repeated blood glucose levels during this time were obtained

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)
and documented as 55 and 104. The doctor (MD) was updated on resident's condition and orders were obtained for STAT (now) blood work which included a CBC/ CMB (complete blood count/ comprehensive metabolic panel), reduce [MEDICATION NAME] (insulin) to 10 ml (milliliters) at HS (hour of sleep) and to notify the MD for blood glucose levels below 60 or greater than 300.
laboratory results dated [DATE] documented a glucose level of 71 L (low), with a reference range of 74-100 mg/dl (milligram/ deciliter).
A nursing Progress Note dated 2/5/18 documented the following:
- 4:15 AM, Registered Nurse Supervisor (RN #6) documented the resident was found unresponsive, except to a sternal rub with fixed and dilated pupils. The resident's skin was cold and clammy, the bed linens and the resident's gown were wet. The following vital signs were documented, pulse ox (PO2, amount of oxygen in the blood) 91 % (percent, normal 95-100 %), and pulse rate of 104 (normal 60-100). A new order was obtained to administer 1 mg (milligram) of [MEDICATION NAME], discontinue the HS [MEDICATION NAME] and to increase oxygen (O2) to 4L (liters) for comfort till responsiveness returned. After the administration of [MEDICATION NAME], the resident became responsive to verbal commands, and was able to eat and drink. The BSFS (blood sugar fingerstick) slowly increased to 89 by 4:45 AM. The note did not include a blood glucose level but documented will continue to monitor for [DIAGNOSES REDACTED].
- 7:48 AM, Licensed Practical Nurse (LPN #7) documented she was called to the resident's room by a CNA (certified nurse aide, unidentified), the resident was cold, clammy and unresponsive. The Supervisor was notified. The following glucometer readings (blood glucose levels) were documented: 4:00 AM the FS was 34, 5:00 AM the FS was 89, and at 6:30 AM the FS was 93. The resident was verbally responsive at this time, skin warm and dry to touch.
- 9:16 AM, LPN #7 documented that she was called to the resident's room by a CNA (unidentified). The resident was found with cold and clammy skin, and the resident was diaphoretic (sweating heavily). The LPN obtained a fingerstick (blood glucose level) of 38. The Supervisor was called to the unit. The resident's BP (blood pressure) was 170/90 (normal 120/80). A second fingerstick was obtained after orange juice and sugar was given, and the blood glucose was up to 58.
A nursing Progress Note dated 2/6/18 at 1:00 AM, RN Supervisor #6 documented the resident was admitted to the hospital with [REDACTED].
A hospital Discharge Summary dated 2/13/18 for a discharge date of [DATE] documented discharge [DIAGNOSES REDACTED]. The
discharge summary documented to PLEASE AVOID GIVING THIS PATIENT INSULIN (LONG OR SHORT ACTING). Patient has had multiple
admissions for [DIAGNOSES REDACTED], transiently high blood sugars are preferred to low blood glucose. The summary also documented the PATIENT NO LONGER REQUIRES INSULIN and was at high risk for [DIAGNOSES REDACTED]. Additionally, included
instructions to STOP TAKING THESE MEDICATIONS - Insulin [MEDICATION NAME] ([MEDICATION NAME], long-acting insulin to help
control blood sugar level) 10 units sub-Q (subcutaneous- beneath the skin) injection, daily at bedtime.
A Nursing Admit/ Readmit Screen dated and signed by RN Supervisor #6 on 2/16/18 documented admitting [DIAGNOSES REDACTED].
A Medication Review Report signed by physician on 2/17/18 documented orders for Insulin [MEDICATION NAME] Solution Pen-injector 100 unit/ ml (milliliters)- inject 10 unit subcutaneously at bedtime for DM with start date of 2/16/18. There were no orders or instructions to monitor the residents blood glucose levels.
A Physician's Comprehensive Nursing Home Visit- Admission History & Physical dated and signed on 2/17/18 documented [DIAGNOSES REDACTED]. The resident was receiving rehabilitation at the facility when she was transferred back to the hospital on [DATE] for [DIAGNOSES REDACTED] and altered mental status. The physician's documented Assessment/ Plan included: Altered Mental Status secondary to [DIAGNOSES REDACTED], resolved, monitor glucose and DM on [MEDICATION NAME].
The Medication Administration Record [REDACTED]. There was no documented evidence of glucose monitoring.
Review of the Progress Notes dated 2/16/18 through 2/18/18 revealed there was no documented evidence of glucose monitoring.
Review of a document entitled Weights and Vitals Summary for blood sugar results revealed there was no glucose testing documented for the month of (MONTH) (YEAR), except for the result of 222 on 2/19/18.
A nursing Progress Note dated 2/19/18 documented:
- 1:28 AM, LPN #2 documented the resident was alert with some confusion. PO2 was 95% with O2 on as ordered. The resident was able to participate in ADL's (activities of daily living), and could self-propelled wheel chair. Meds were given as ordered and her appetite was good.
- 9:00 AM, the former Assistant Director of Nursing (ADON) documented a change of condition, the resident was lethargic and slumped over in bed. At 9:05 AM, IM [MEDICATION NAME] was given for a fingerstick (blood glucose) of 37. The resident became more alert after the administration of [MEDICATION NAME] and was given juice with sugar. The MD was updated on the hypoglycemic event.
- 10:52 AM, an RN #7 RCC (Resident Care Coordinator) documented there was good effect from [MEDICATION NAME] administration,
a FS was retaken and the result was 222. Ambulance was called by a 4th party per EMT (emergency medical technician). Resident refused to go out to hospital, and stated she was not having any chest pain. EMT did encourage resident to go for evaluation and she agreed. The resident was transferred to hospital for evaluation.
- 8:58 PM, RN Supervisor #6 documented the resident was admitted to the hospital at 2:59 PM with [DIAGNOSES REDACTED].
A hospital Discharge Summary dated 3/1/18 documented an admitting [DIAGNOSES REDACTED]. The patient was given [MEDICATION
NAME] and sent to hospital. Upon arrival to the hospital the glucose had normalized and appropriately responded to treatment. Subsequently while in the ED (emergency department) the patient had an alteration in mental status and was found to have a fingerstick glucose of 21. The patient was given 1 amp (25 grams) of D50 ([MEDICATION NAME] in 50 ml (milliliters) - fluids given intravenously to help raise blood sugar level) and was subsequently admitted for refractory [DIAGNOSES REDACTED] (unmanageable). The summary also documented [DIAGNOSES REDACTED]- acute metabolic [MEDICAL CONDITION]
mostly likely due to low blood sugars. Additionally, avoid any long acting insulin agents in patient as this is second or third hospitalization for [DIAGNOSES REDACTED].
During an interview on 10/26/18 at 11:22 AM, the Medical Director stated, I would say that 100% of the time I will always go by what the hospital discharge summary would recommend for a resident readmitted into the facility. I have 48 hours to see the resident when they come back from the hospital. The nurses/ supervisors would be the one reading the discharge summary recommended medications to me to order. I go by what the nurses tell me and trust the nurses as to what the discharge summary recommends regarding the medications and other recommendations on it. I do not know why the insulin was ordered if the discharge summary had to stop it, the nurse may have miss-read the orders to me. I usually try to read the discharge summaries from the hospital when I come in and see the resident. I do not know why I did not address the recommendations in my history and physical on 2/17/18 or discontinue the insulin. When a diabetic is admitted or readmitted back to the facility they should have their glucose level be monitored and that is standard for every diabetic. The facility should be monitoring the resident's glucose for the first seven days, four times a day regardless. If the resident becomes stable they should be monitored at least 1 to 2 times a week regardless. As to why the glucose levels would have been discontinued on 1/31/18, I would have to think someone mistakenly clicked something and caused it to be deleted from the system. She should have been having the glucose levels done. The Physician further stated because she has a [DIAGNOSES REDACTED]. I would say this caused harm for such a brittle diabetic.
During an interview on 10/26/18 at 12:53 PM, the ADON stated, When a resident is readmitted back into the facility from the hospital, you would use the discharge summary from the hospital and read from that to the physician to confirm the orders. Just the RN's would do this for admits and re-admits.
During a telephone interview on 10/26/18 at 1:15 PM, former RN Supervisor #6 Supervisor stated, she would read the discharge summary medications to the physician, get the medications approved by the physician, and place them in name of computer system. The RN stated she did not recall if she read to stop the insulin to the MD but stated, I usually read off the whole discharge summary. If it said to stop the insulin, I am not quite sure why I had the MD order it. Additionally, stated, when a resident comes back on insulin and is a diabetic I would usually ask the Physician if they would like fingerstick levels.
During an interview on 10/26/18 at 2:36 PM, the Director of Nursing (DON) stated, the process for taking orders off (transcribing) when a resident is admitted or readmitted to the facility is that the RN would read off the discharge summary to the physician what was recommended, and the nurse would then confirm the orders with the physician and put them in the computer. By reading these orders from Resident #241's discharge summary, I would say the resident should not have been getting the insulin as it says to stop. The error is on the person who took the orders off. In addition, the DON stated, At that time the RN may or may not have asked the MD for glucose levels it would depend on the resident's

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) situation. We would not have necessarily monitored the glucose because she was on [MEDICATION NAME]. During an interview on 10/26/18 at 2:49 PM, the Administrator stated, The DON or myself would do a review of negative outcomes. There is a process for reviewing outcomes. I do not know if we did a review on this issue. The RN Supervisor who took the orders was not released (terminated) because of this situation, she resigned. When asked if this chart was reviewed for the negative outcome of this resident it was stated well we really need to look at the chart to see what is going on. During an interview on 10/26/18 at 3:44 PM, the RN, Regional Director of Quality Assurance stated, When any resident comes back to the facility from the hospital it should be reviewed. It should be reviewed by the nurses and the DON. I would absolutely encourage the physician to do blood glucose monitoring on any diabetic coming back on insulin. The best practice would encourage the MD to monitor the glucose levels, but ultimately the decision is up to physician. During an interview on 10/29/18 at 8:50 AM, the following were present RN/ Administrator, Director of Strategic Planning; RN Regional Director of Quality Assurance; DON; Administrator and Assist Administrator from the facility. The following was stated by the RN/ Administrator, Director of Strategic Planning, The DON had completed an entire chart review with an investigation completed back in (MONTH) (YEAR) when the incident had occurred. A 100% audit of the entire building for all residents with diabetes mellitus was completed in (MONTH) and in-services were done with all the nurses at the time. It was stated that they had signatures from all the nurses from this in-service. The audit was for six weeks, where they found some residents were without fingerstick orders, therefore it was corrected by receiving orders for the fingerstick to be done. The RN Supervisor who transcribed the order incorrectly was disciplined. There was a Quality Improvement Tool completed, so therefore the DON did identify the issue in (MONTH) and corrective actions were taken. The entire building this past weekend was re-educated again regarding glucose monitoring. When asked what they felt went wrong, The DON stated, I think the nurse read the orders on the discharge summary wrong to the doctor. The doctor should have looked at the discharge summary. It is expected the doctors read the discharge summary. The RN/ Administrator, Director of Strategic Planning stated, The nurse must not have seen the discharge summary state do not give the insulin. The doctor should have acknowledged that he reviewed the discharge summary either by signing the copy or writing it in his note on 2/17/18. Review of the facilities investigation revealed on 2/21/18 the DON initiated an investigation secondary to a QI (Quality Improvement) review. The investigation documented that all nurses were educated on the need to monitor blood sugars on any resident admitted to the facility with a [DIAGNOSES REDACTED]. The nurse transcribing the orders was educated and disciplined. A full house review was initiated on all residents with [DIAGNOSES REDACTED]. Review of the In-service Sign in Sheets dated (MONTH) 22, (YEAR) revealed three nurses were educated in February, two nurses in March, five in April, one in (MONTH) and one in September. The in-service addressed the monitoring of residents with a [DIAGNOSES REDACTED]. During an interview on 10/29/18 at 10:01 AM, the RN/ Administrator, Director of Strategic Planning stated, No we did not implement anything for Quality Assurance regarding the doctors reviewing hospital discharge summaries. We do not have any medication errors for the month of (MONTH) (YEAR). We only have two since (MONTH) (YEAR), one in (MONTH) (YEAR) and one in (MONTH) (YEAR). 415.12